

DO THE ENDS JUSTIFY THE MEANS? NURSING AND THE DILEMMA OF WHISTLEBLOWING

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ABSTRACT

Background:

Patient advocacy and a desire to rectify misconduct in the clinical setting are frequently cited reasons for whistleblowing in nursing and healthcare.

Aim:

This paper explores current knowledge about whistleblowing in nursing and critiques current definitions of whistleblowing. The authors draw on published perspectives of whistleblowing including the media, to reflect on the role of the media in health related whistleblowing.

Conclusion:

Whistleblowing represents a dilemma for nurses. It strikes at the heart of professional values and raises questions about the responsibilities nurses have to communities and clients, the profession, and themselves. In its most damaging forms, whistleblowing necessarily involves a breach of ethical standards, particularly confidentiality. Despite the pain that can be associated with whistleblowing, if the ends are improved professional standards, enhanced outcomes, rectification of wrongdoings, and, increased safety for patients and staff in our health services, then the ends definitely justify the means.

INTRODUCTION

When considering whistleblowing as an option for nurses, many questions arise. These questions include:

- Whose interests are being served?
- Who could be damaged?
- What is the motivation for whistleblowing?
- What are the consequences of whistleblowing to the whistleblowers and the organisation?
- Is there any other way to draw attention to the issue?
- Will the act of whistleblowing solve the problem?
- Do the ends justify the means?

Aim of this paper

This paper aims to explore current knowledge about whistleblowing in relation to nursing. The specific objectives are to:

- Propose a definition of whistleblowing that is compatible with nursing.
- Examine the dilemmas associated with whistleblowing as it relates to nursing.
- Explore the repercussions of whistleblowing as represented in the literature.
- Draw on key published perspectives about *The Bristol Affair* to focus on the role the media can play in health related whistleblowing.

Defining whistleblowing

Whistleblowing may seem to be a taken-for-granted term that has a clear meaning and little room for interpretation. However, a search of published definitions

reveals various understandings and meanings associated with the term. In their paper on whistleblowing, Ahern and McDonald (2002) defined it as any reporting of misconduct in the workplace. Elsewhere, McDonald and Ahern (2002, p.16) define nurse whistleblowers as 'a nurse who identifies an incompetent, unethical, or illegal situation in the workplace and reports it to someone who may have the power to stop the wrong'. These definitions are problematic because they do not delineate between reporting to outside agencies such as the media, and reporting undesirable events according to accepted organisational guidelines. In effect, the aforementioned definitions position reporting questionable practices or undesirable outcomes to individuals, groups, or bodies that are part of a discipline or an organisation's usual problem-solving strategy, as whistleblowing.

Definitions that position all forms of reporting as whistleblowing raise the issue of whether whistleblowing is internal or external to an organisation. It is our contention that internal reporting - that is, reporting which is adhered to as part of guidelines for employees, such as completion of incident forms for poor patient outcomes or unforeseen events, verbal reporting to line managers or other appropriate staff, is ideal professional conduct and should be encouraged. Such reporting is carried out in the interests of quality improvement, incident debriefing, clinical supervision, and maintenance of professional standards and integrity in practice.

Describing internal reporting of undesirable outcomes or poor practice as whistleblowing could make it seem in some way undesirable or as having detrimental ramifications and therefore, something to be avoided. Alerting professional bodies or to structures internal to an organisation about poor practice or other issues of concern, is wholly acceptable and desirable behaviour. For one thing, it does not necessarily involve a breach of confidentiality, which occurs when external avenues are involved. Furthermore, using approved internal or professional problem-solving structures as mechanisms to draw attention to internal problems, and to improve practice is the minimum required standard for all health professionals including students, and should be an accepted work-related event.

On the contrary, far from being a typical and common event, whistleblowing is an extraordinary event. It is associated with stress and personal risk (Ahern and McDonald 2002). It may involve the whistleblower undergoing personal inner conflict about the decision to blow the whistle, and it may be associated with breaching ethical codes such as confidentiality. In order to justify such a breach, all appropriate internal avenues that exist to right the wrong must first be exhausted (Fletcher et al 1998). Fletcher et al (1998) also states that where internal avenues have not been exhausted, whistleblowing can raise concerns about whistleblower motives, and suggests revenge and desire for attention as possible motivating factors.

Understanding the public nature of whistleblowing is crucial to understanding the risks and dilemmas associated with the phenomenon. Wilmot (2000, p.1051) define whistleblowing as 'the public exposure of organisational wrongdoing', but also acknowledged its inherent antagonistic nature when he positioned it as 'part of a spectrum of increasingly confrontative actions against miscreant organisations by their employees' (Wilmot 2000, p.1051). Dawson (2000, p.2) provided a more detailed definition and raised the issue of privileged information. He defined whistleblowing as a 'deliberate, voluntary disclosure of individual or organisational malpractice by a person who has had privileged access to data, events or information about an actual, suspected or anticipated wrongdoing within an organisation that is within its ability to control' (Dawson 2000, p.2).

When considering whistleblowing in nursing, we sought a definition that captured the idea that it involves taking privileged information to an individual or body who would not normally be involved with organisational problem-solving. Thus, for the purposes of this paper, we consider whistleblowing to be the reporting of information to an individual, group, or body that is not part of an organisation's usual problem-solving strategy. Whistleblowing is a phenomenon where a party or parties take matters that would normally be held as confidential to an organisation, outside that organisation despite the personal risk, and potentially negative sequelae associated with the act.

The whistleblower

Iliffe (2002) constructed whistleblowing as an imposed rather than a chosen situation. She suggested that whistleblowers are 'ordinary' people who find they witness or otherwise become aware of situations that force them into a decision of having to speak out or remain silent. Both decisions carry consequences. Whistleblowers are generally cast in the literature as brave and courageous individuals, who act to maintain standards against the might of an organisation (Jackson and Raftos 1997), and who do so sometimes at great personal cost (Iliffe 2002). An alternative view, and one that is sometimes promulgated by targeted organisations, is that whistleblowers are malcontents, who will stop at nothing to pursue their own agenda, regardless of the destructive and negative sequelae for colleagues and organisations.

In their discussion on whistleblowing in nursing, McDonald and Ahern (2002) proposed the concept of the non-whistleblowers, which she defined as a nurse who, on identifying incompetence, illegal, or unethical practices, adopts methods other than whistleblowing to resolve the situation or address the allegations.

Possible strategies include talking directly with a nursing unit manager about the issues, or reporting the issues on an incident form or similar document (McDonald and Ahern 2002). We suggest that these

actions are in keeping with reporting and reflection associated with maintaining professional standards and integrity in practice and would hesitate to label persons engaging in these activities as non-whistleblowers.

Organisational culture and whistleblowing

Health care institutions are hierarchical structures and so carry all the entrenched flaws and difficulties of such structures. Furthermore, some organisations create and maintain cultures in which mistrust abounds. Speedy (2004, p.156) states that when employee trust is violated, 'a climate of suspicion and vigilance against wrongdoing' is created. These organisations create cultures of reduced loyalty and can cause employees to feel violated, betrayed, and liable to seek reprisal (Speedy 2004), which in turn becomes a motive or factor in whistleblowing. In making the plea that 'when all is said as done, the whistleblower must blow the whistle for the right moral reason', Fletcher et al (1998, p.2) positions examination of, and reflection on, the motives for whistleblowing as crucial steps for nurses considering whistleblowing.

Speedy (2004) also suggested that health care organisations may have a greater potential for abuse of workers than other organisations. The abuse can take the form of marginalising and silencing people and in general making it difficult for people to speak out against issues or practices that trouble them (Speedy 2004). Health professionals are socialised into a culture of silence (Jackson and Raftos 1997), which contributes to a climate in which whistleblowing, rightly or wrongly, is one of the few avenues open to health professionals who are troubled by poor practice, and see a pressing need for change.

The dilemmas associated with whistleblowing

Whistleblowing is represented in the literature as an avenue of last resort (Jackson and Raftos 1997; Wilmot 2000). Wilmot (2000) states that whistleblowing can be likened to a spectrum. At one end of the spectrum is the worse case scenario where the effects of whistleblowing are disruptive and experienced as negative to all concerned. On the other end of the spectrum whistleblowing may inflict minimal scars on the organisation or stakeholders (Wilmot 2000).

In an ideal world there would be no dilemma associated with blowing the whistle on poor practice or other institutional short-comings. The dilemmas arise when nurses go outside organisations with privileged information in an attempt to have their concerns addressed. However, it can be argued that nurses are left with little choice. The literature provides numerous accounts of whistleblowing employees who have made many attempts to rectify wrong doing through internal channels, however when they are unsuccessful they turn to external channels in an effort to be heard (Jackson and Raftos 1997). This type of whistleblowing has been

described as a 'morally courageous action' (Fletcher et al 1998, p.2).

Primarily, whistleblowing raises dilemmas for nurses around issues such as patient advocacy and duty of care and can raise conflicts around organisational and professional allegiances. Tensions arise between the perceived need to effectively problem-solve, and the need to adopt a 'damage-control' stance in terms of damage to institutions. Undermining public institutions such as hospitals and health facilities has far-reaching effects to the community the institution serves. The lack of community confidence in and antipathy towards institutional staff (who may not have any association with the alleged poor practices) that can arise as a result of whistleblowing can be devastating. Furthermore, questions about natural justice arise, in that individuals and organisations may be subject to public attack in ways that are very difficult to respond to.

Thus, whistleblowing presents nurses with a conundrum. Brodie (1998) describes it as a moral dilemma, stating that nurses choosing to blow the whistle 'do so out of social consciousness and moral commitment' (Brodie 1998, p.1). Patient advocacy is also commonly associated with whistleblowing acts (Ahern and McDonald 2002; Mallik 1997). Wilmot (2000) suggested that whistleblowing can be a calculated act of sabotage which raises another view. However, regardless of motive, it is undoubtedly a most difficult decision that has moral, practical, ethical and professional implications (Wilmot 2000). Once the decision is taken to blow the whistle the accusations can take on a life of their own. Often, there can be no turning back - particularly when the allegations became public.

The repercussions of whistleblowing

Wrestling with the system, as a result of feeling compelled to speak out and take action comes at a cost. In hierarchical organisational structures seniority counts. It has been suggested that, within the health professions, those who challenge the abilities of superiors or the integrity of organisations are viewed as the problem, rather than the issues they raise (Faunce and Bolsin 2003). In this way, attention is drawn away from the issues raised by whistleblowers to the whistleblowers themselves.

Once an act of whistleblowing occurs, there are a number of documented detrimental personal and professional repercussions (De Maria 1994; Jackson and Raftos 1997; Ahern and McDonald 2002). The literature paints a bleak picture for whistleblowers and the evidence suggests that whistleblowing acts affect whistleblowers in a number of ways. These effects include feelings of disillusionment, powerlessness, intense frustration, conflict, anger and isolation in the whistleblowers (Brodie 1998; De Maria 1994; Jackson and Raftos 1997). Disciplinary action, hostility, ridicule, ostracism, scrutiny, and, personal attacks may come from colleagues and the institution (Brodie 1998; De Maria 1994; Jackson and

Raftos 1997). Other problems for whistleblowers can include insomnia, headaches, and fatigue (McDonald and Ahern 2002).

The literature reveals a culture in which whistleblowers are subject to a number of official and unofficial reprisals, including workplace violence and intimidation (Ahern and McDonald 2002). Some writers suggest that whistleblowers contemplate resignation (Jackson and Raftos 1997; McDonald and Ahern 2002). It may be that the degree of animosity and resentment is so great that the whistleblower has no choice but to leave the organisation. The most common form of official reprisal is formal reprimand and being castigated by management (De Maria 1994). The second type of reprisal include punitive transfers, which were often initiated to ease tension in the workplace (De Maria 1994). De Maria (1994) identified three common unofficial reprisals experienced by staff as ostracism, scrutiny, and, personal attacks.

Where nurse whistleblowing is concerned, most often all stakeholders (nursing, organisation, other nurses, community, professions, whole hospital staff) are affected by the allegations raised by the whistleblowers. Irritability, cynicism and isolation are reported in the workplace (McDonald and Ahern 2002). McDonald and Ahern (2002) found that whistleblowers and non-whistleblowers experienced similar percentages of physical illness such as altered energy levels, sleep disturbances, and digestive system disturbances, while non-whistleblowers had a higher percentage of emotional illness from feelings of shame, guilt and unworthiness.

As Wilmot (2000) suggested, whistleblowing is inherently adversarial and confrontational. It pits parties against each other and creates a climate of hostility and mistrust. In addition to the effects on the whistleblowers, whistleblowing can create a panic-type reaction in which organisations rush to prepare themselves for the external scrutiny that is certain to follow. Furthermore, staff not directly involved in the allegations, or the whistleblowing activities are under siege, because they are also placed under scrutiny. During this time, organisations remain bound by confidentiality and are often not able to tell their side of the story to the public. Damaging information can continue to be promulgated while organisations and other staff are not able to respond effectively.

The media and whistleblowing

The media is a fairly common, if controversial, means whistleblowers use to draw attention to their particular issue. Litley (2001) reported a case in the UK in which a nurse wrote to a newspaper alleging that elderly inpatients were not receiving adequate care, to the point that their lives were jeopardised. Findings of an appeals tribunal ruled that writing to a newspaper was a reasonable and acceptable way of raising concerns (Litley 2001).

Later in the article there is mention of the anger and offence felt by the colleagues of the whistleblowers whose actions had cast them into the unpleasant heat of public scrutiny without benefit of being able to defend themselves (Litley 2001). Although the whistleblower in Litley's paper later apologised to his colleagues, one is left wondering if there are not more appropriately, equally effective and potentially less damaging ways that nurses and other concerned health workers can raise issues of concern.

Unwanted media attention can place nurses and other staff under unfair scrutiny. The adversarial and combative aspects of whistleblowing are never more evident than when the media is involved. Both the whistleblowers and the 'offender' organisation are subject to the harsh gaze of public scrutiny. Whistleblowers may be inexperienced in dealing with the media and may be themselves cast in a poor light. However, whistleblowers and the 'offender' organisations are not the only ones who suffer. Bystanders including other organisational staff can get caught in the skirmishes, as they too are scrutinised and sometimes blamed, despite the fact that their story is seldom told. Relatives of patients and members of the community can also become implicated in the reactionary rush that follows.

However, it is neither possible nor desirable to merely dismiss the media. The media has a role as public 'watch dog' and a mandate to keep the public informed. The media is especially important in health because there is a perception that the health professions are unused to being held publicly accountable. The role of the media in whistleblowing can spark bitter controversy in the medical community. However, there are occasions where the media have rightfully raised concerns about health practices or practitioners, with very positive effects. In some cases journalists have adopted the role of whistleblower.

The following exchange highlights two perspectives about the role of the media in publicising the events that became known as The Bristol Affair. Emeritus Professor Peter Dunn aired his views that 'biased, misleading, and often inaccurate information' caused untold damage in this case.

'Many colleagues, patients, and friends of James Wisheart, Janardin Dhasmana, and John Roylance will have been deeply shocked by the unjust way in which the three men have been treated. Every sympathy is due to those who have lost loved ones. However, whereas doctors will readily understand the aggressive grief some parents have shown, their anger should surely be reserved for the news media (and their informants) that have misdirected this grief against the Bristol surgeons using a sustained stream of biased, misleading, and often inaccurate information. And the defendants' explanations remained almost entirely unreported after they presented their case. The confidence of the public in the medical profession has been badly damaged by this affair and by its handling by

the GMC [General Medical Council]. So, too, has the morale of doctors. If justice is to be done, confidence restored, and doctors are not to act defensively in the future the forthcoming public inquiry must set the record straight' (Dunn 1998, p.1144).

James Garrett, head of the current affairs team that initially publicised the story issued a response in a subsequent issue of the British Medical Journal in which he asserted that painstaking research was carried out to ensure accuracy:

'It was my programme in March 1996 about the Bristol heart surgery tragedy, for Channel 4's current affairs series Dispatches, that prompted the General Medical Council (GMC) to investigate what, it subsequently became clear, was the medical scandal of the century. Since then I and my colleagues have continued to report on these cases. I wish to reply to Dunn's allegations about media reporting of the tragedy; I am, presumably, one of those whom he pronounces guilty of "using a sustained stream of biased, misleading, and often inaccurate information". According to Dunn, bereaved parents should direct their grief and anger over the death of their children towards people like me, rather than the surgeons who operated on the children and have since been found guilty of serious professional misconduct. "Shoot the messenger" is the age old response of those who dislike the message. The Dispatches programme was researched painstakingly over many months to ensure the accuracy of the story it told. Had it been "misleading" or "inaccurate" it would surely have attracted a writ for defamation from one or more of the three doctors who were named. However, no writ followed the original programme or any of the four documentaries and dozens of shorter reports that HTV has produced since. Dunn complains that the views of the three doctors have received inadequate attention in the media. I have personally written many letters to James Wisheart, Janardin Dhasmana, and John Roylance, seeking to report their views. None of them has taken up my offer, which remains open. Their refusal to contribute notwithstanding, HTV reported the defence they made at the GMC. Interviews with lay supporters - which we have also broadcast - are, ultimately, no substitute for the doctors' own words... Dunn should look closer to home for people to blame if the public does not like what we showed them and demands reform' (Garrett 1998, p.1592).

Investigative journalists in particular, tend to take great care to provide balance in their arguments and carefully check and cross check their sources. In many cases they have provided crucial and timely information. A compelling example of media whistleblowing took place in New Zealand as a result of the publication of an article in the mainstream media exposing unethical experimentation on women. The article was the catalyst for an investigation led by Judge Dame Silvia Cartwright into the treatment of women with abnormal cervical

smears the National Women's Hospital in Auckland. The inquiry culminated in *The Cartwright Report* (1988), which resulted in a series of recommendations to improve women's health care, raise awareness of ethical issues, and place patient's rights firmly on the agenda (Women's Health Action Trust 1998).

This type of media involvement plays a crucial role in protecting the public and in making the health professions accountable. In the end, it has probably saved many lives. The media was also instrumental in raising public alarm at the events occurring at Chelmsford Hospital in Sydney, Australia. These concerns led to *The Chelmsford Hospital Inquiry* (Hart 1996) and revealed (arguably) the worst case of psychiatric malpractice in Australian history. As evidenced in Justice Slattery's comments, the secrecy surrounding practices at the hospital was entrenched and without the influence of the media, may have remained so.

'... there was a systematic cloak of secrecy about the treatments, a blanket on the disclosure of information relating to it and a fraudulent cover-up of deaths and other incidents at the hospital' (Slattery cited in Bagnall undated).

Clearly, history has shown the media can play a powerful role in raising public awareness about health-related practices and wrongdoings in health organisations. Furthermore, as has been demonstrated in the examples presented here, the media has the power to be a potent catalyst for inquiry processes that compels health professionals to reflect on their attitudes and practices, and to effect positive changes in health care practice.

However, the other side of the coin is that while raising matters in the media certainly has the effect of placing them firmly under the public gaze, the sources of information cannot be guaranteed or even identified in some cases. Though most reporting in the media is responsible, the nature of health care is that both sides are often not able to 'tell their stories'. Accused individuals and organisations remain bound by confidentiality. Legal advisors might advise accused parties not to talk to the media. As a result information may not be balanced or completely accurate and may be taken out of context. Misinformation can cause alarm and panic that can quickly spread. Although altruism and the 'public good' may be cited as possible motivating factors for whistleblowing in the first place, things can quickly get out of control.

In the final analysis, the whistleblower needs to make a considered decision about approaching the media. If they choose to do so they need to carefully select the type of media to approach. The accountability for such decisions rests with the whistleblower, and they must live with the outcomes of their decisions.

Looking ahead: Solving the whistleblowing dilemma

It could be argued that if health care organisations had appropriate and sound internal structures in place to ensure employees concerns are addressed, whistleblowing would never occur. However, as matters stand, the literature is replete with examples of nurse/employees exhausting all internal avenues with management and organisations as they strive to draw attention to and rectify the wrong doing (eg. Jackson and Raftos 1997).

In Australian nursing, there is an evident paucity of information relating to whistleblowing. In the February 2002 *Australian Nursing Journal*, Iliffe described whistleblowing as a difficult area and asked nurses to respond and debate the issue. At that time she drew attention to the fact that no policy concerning whistleblowing was currently in place to guide nurses and highlighted it as an important omission (Iliffe 2002). In conclusion, Iliffe called for discussion and debate about issues related to whistleblowing, and indicated a need for policy to be developed to deal with whistleblowing situations (Iliffe 2002).

Recommendations for the establishment of a specific task force to assist staff who may be involved in a whistleblowing situation have been made in Australia (Jackson and Raftos 1997). The responsibility could be taken by an existing national body, or an independent body could be formed. The group could provide a platform for nurses to discuss issues around whistleblowing, and could provide information and support for whistleblowers (Jackson and Raftos 1997).

Medicine has begun to act to effect change. Faunce and Bolsin (2003) reported that the Australian National University has initiated strategies within the medical curriculum so that students will be able to understand the inter-relationship between human rights, ethical and legal principals, and how they intersect with safety and quality issues. Students will be exposed to simulated learning experiences, including whistleblowing. Nursing too needs to look to turning around the enculturation processes that condone abusive and poor practices.

CONCLUSION

Clearly, whistleblowing presents nursing with a continuing ethical and moral dilemma. It is important nurses engage in a debate about whistleblowing and examine ways to ensure standards are met and protect the rights of patients and the wider community. Nurses must be prepared to examine themselves and must continue to advocate for patients, clients and communities. Nurses must not avert their gaze when abuse, neglect or violations of individual and community rights occur.

However, it is not acceptable for nurses who blow the whistle to experience the extreme personal and professional sequelae described in the literature. Furthermore, there must be mechanisms for ensuring rights, and addressing abusive, neglectful and otherwise unacceptable practices without raising public panic and without creating unendurable conditions for nurses and other personnel who remain and continue to provide services, and to reflect, rectify and rebuild.

Finally, to answer the question we pose in the title of this paper - do the ends justify the means? Despite the pain that can be associated with whistleblowing, if the ends are improved professional standards, enhanced outcomes, rectification of wrongdoings, and increased safety for patients and staff in our health services, then we say the answer is a resounding yes - the ends definitely justify the means.

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